

**ALABAMA DEPARTMENT OF INDUSTRIAL RELATIONS
ADMINISTRATIVE CODE**

RULE

Division: Workers' Compensation
Chapter: Utilization Management and Bill Screening
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480-5-5-.09 PROCEDURE FOR PRE-CERTIFICATION.

(1) Pre-certification review shall be conducted by telephone and/or facsimile during normal business hours (8:30 a.m. to 4:30 p.m. Central time, Monday through Friday, excluding legal holidays). Written requests may be processed by the URE or employer/agent on a case-by-case basis.

(2) The physician, hospital, or other provider shall initiate the process by calling the employer/agent at least 48 hours or two working days in advance, except for an emergency. The URE or employer/agent shall respond with a review determination to the physician, hospital, or other provider within 48 hours or two working days after the receipt of necessary information. If a patient does not enter the hospital or receive other medical services on the proposed date or within 15 days following that date, recertification shall be required. In such cases, the caller shall contact the URE or employer/agent to reaffirm the previously submitted data for recertification.

(a) The provider shall supply the following information to the employer/agent:

1. Employee's name;
2. Employee's Social Security number;
3. Date of injury;
4. Employee's address;
5. Sex;
6. Employee's date of birth;
7. Name of provider or facility;
8. Provider's or facility's address;
9. Anticipated treatment or admission date;
10. Diagnosis (to include ICD-9-CM codes);
11. Expected length of stay, if applicable;
12. Major procedures and related CPT-4 codes;
13. Plan of treatment;

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14. Complications or other factors requiring the setting requested;
15. Medical justification for planned treatment or inpatient admission;
16. Anticipated surgical procedure, if any;
17. General anesthesia requirement;
18. Attending physician's name;
19. Attending physician's address;
20. Attending physician's phone number;
21. Attending physician's tax ID or Social Security number;
22. A brief summary of how the proposed procedure is related to the patient's work related injury; and
23. Caller's name and number.

(b) The provider shall furnish descriptive/narrative information and the URE or employer/agent shall assist in providing the ICD-9-CM and/or CPT-4 codes.

(3) Criteria for Admission - All non-emergency hospital admissions shall be reviewed using generally accepted criteria to assess the need for the level of care.

(4) The criteria for length of stay shall be based on medical necessity and generally accepted criteria.

(5) Hospital admission requests that clearly conform to paragraph (3) of this Rule 480-5-5-.09 shall be approved and an initial length of stay may be assigned.

(6) Diagnosis or symptoms that do not conform to established clinical criteria shall be reviewed by a registered nurse or physician before approval for treatment or admission is issued.

(7) Physicians shall make the decision on all denials of certification, which constitutes the Second Level Clinical Review as set forth in Rule 480-5-5-.07. Any denial is subject to Peer Clinical Review (Third Level Clinical Review) as outlined in Rule 480-5-5-.07.

(8) A response shall be generated in writing (letter or facsimile) if the treatment or admission is denied. Verbal or facsimile response shall be given within two working days from the time of the receipt of all necessary information.

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Copies of the written response, if required, shall be sent to the requesting provider and shall notify the party of the right to appeal and the appeal process. The denial letter shall contain the following elements: claimant's name, social security number and address; date of accident; date of requested service; procedure requested; name of provider or facility; reason for denial; and the appeals process. The claimant shall be copied on all denial letters.
Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Alabama, 1975, §25-5-293
History: Effective September 12, 1996. Amended: April 13, 2001.